FOR OFFICE USE ONLY	
Date Received:	
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Intern No:	

Arkansas State Board of Pharmacy
101 East Capitol, Suite 218
Little Rock, AR 72201
Tel. 501-682-0190
Fax 501-682-0195
www.arkansas.gov/asbp

Training Plan for an Intern Pharmacist

Please note: You must have a *Training Plan* on file at the Board of Pharmacy in order to receive credit for experience hours. A *Buff Card* will be sent to the pharmacy listed on this *Training Plan* to allow you to work and gain pharmacy experience hours. ***Do not work until the pharmacy has received the Buff Card***

(Please PRINT OR TYPE)

NAME: LAST **FIRST** **MIDDLE**	**INTERN LICENSE #**
HOME ADDRESS:	
CITY: **STATE:** **ZIP:**	
MAILING ADDRESS: If different from above, indicate your mailing address:	
CITY: **STATE:** **ZIP:**	
HOME PHONE NUMBER: ( )	**DAYTIME PHONE NUMBER: ( )**
SOCIAL SECURITY NUMBER:	
ACADEMIC CLASSIFICATION: **P1:** _____ **P2:** _____ **P3:** _____ **P4:** _____	
TYPE OF PRACTICE: Community/Retail _____ Hospital _____ Research _____ Other _____ If you checked "other", please describe here. _____	
PHARMACY NAME:	**PHARMACY PERMIT #:** (AR######, HP######)
PHARMACY ADDRESS:	
CITY: **STATE:** **ZIP:**	
PHARMACY PHONE NUMBER: ( )	**PHARMACY FAX NUMBER: ( )**

Name of Intern Pharmacist: _____
(Please type or print) *First* *Middle* *Last*

Start Date for this Training Plan: _____

Expected End Date*: _____

I will be employed approximately _____ hours per week.

**NOTE: All training plans expire May 1 of each year.*

Intern Agreement: *Please carefully read and sign below.*

I understand that, as an intern, I may not perform any duties required of a pharmacist except when I am working under the direct and personal supervision of a pharmacist preceptor. I also understand that should I perform any duties which I am not licensed to perform, or should I take charge of and operate a pharmacy in the absence of a pharmacist, I am placing my ability to become a licensed pharmacist in jeopardy.

I further understand that I must have a *Training Plan* on file at the Board of Pharmacy in order to receive credit for experience hours. A *Buff Card* will be sent to the pharmacy where I plan to gain pharmacy experience hours. I cannot work until the pharmacy has received the *Buff Card*.

I must submit a record of my intern experience on the *Affidavit of Experience*, certified by the preceptor under whose immediate supervision such experience was attained, if I expect to receive credit for such experience toward completion of my experience requirement.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the registration. I hereby certify under penalty of perjury under the laws of the State of Arkansas to the truth and accuracy of all statements and representations made in this application and that I personally completed the application. I understand that I must notify the Board in writing of any change of address during my internship. I have read and understand the instructions and statements on this application.

_____
Signature of Intern Pharmacist Date

Preceptor Agreement:

I accept the responsibility to personally supervise _____,
(please print or type the intern's name)
an intern pharmacist, at all times when he/she is performing duties that are defined as the practice of pharmacy in this pharmacy. The intern pharmacist will work approximately _____ hours per week.

_____
Preceptor's Name
(please type or print)

Alternate Preceptor's Name
(please type or print)

License #: _____ License #: _____

_____
Preceptor's Signature

Alternate Preceptor's Signature

Date: _____ Date: _____